



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

RE: CCN: 245635
Cycle Start Date: November 6, 2024

Dear Administrator:

On November 6, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping".

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245635	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/6/2024
NAME OF PROVIDER OR SUPPLIER ST JOHNS ON FOUNTAIN LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 1771 EAGLE VIEW CIRCLE ALBERT LEA, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

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F 623	Continued From Page 1 and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a transfer notice was given to 2 of 2 residents (R25, R19) and/or family member upon transfer to the hospital reviewed for hospitalization. This deficient practice had the potential to affect all 68 residents residing in the facility. Findings include: R25's facesheet printed 11/6/24, included Parkinsonism (condition that affects movement), pneumonia, atrial fibrillation (the heart's upper chambers beat chaotically and irregularly), displaced fracture of second cervical vertebra (broken bone in the neck region of the spine) and fracture of nasal bones. R25's significant change Minimum Data Set (MDS) assessment dated 8/13/24, included a brief interview for mental status score of 15 indicating intact cognition. A progress note revealed R25 had been transferred to the hospital on 8/4/24 at 3:17 a.m. via ambulance. The medical record lacked documentation which would indicate a transfer notice had been given to the resident and the resident representative. On interview 11/4/24 at 3:25 p.m., R25 indicated he doesn't remember getting any papers prior to his transfer to the hospital. Upon request of the transfer notice, the administrator on 11/6/24 at 12:01 p.m., indicated via electronic communicate the only transfer notice for R25 was the one that was sent to the Ombudsman and there was no other transfer agreements that could be located. On interview 11/6/24 at 11:43 a.m., registered nurse (RN)-D indicated the facility has a bed hold that is sent with the resident, but was not aware of a transfer notice form shared with the resident or the family. RN-D added the resident and the family are both told verbally why they are being sent and a progress note written.			

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F 623	Continued From Page 2 On interview 11/6/24 at 11:49 a.m., licensed practical nurse (LPN)-A indicated the only paper that is given to the resident upon transfer to the hospital is the bed hold. LPN-A was not able to locate any transfer agreement given to R25 and family. R19's facesheet printed on 11/6/24, included diagnoses of dementia and chronic kidney disease. R19's significant change MDS assessment dated 9/19/24, indicated R19's brief interview for mental status (BIMS) score was 99, meaning cognition was not able to be assessed. R19 was rarely/never understood and sometimes could understand. R19 didn't walk and was dependent upon staff for most activities of daily living. During an interview on 11/4/24 at 4:02 p.m., R19 verbalized hospitalization within the past few months, but did not recall anything about a bed hold or transfer notice. Review of the electronic medical record indicated a bed hold notice was present, however no transfer notice. During an interview on 11/5/24 at 10:49 a.m., RN-E explained R19's BIMS score of 99 versus the ability for R19 to communicate information to surveyor during an interview. RN-E stated R19 had been improving significantly; was able to talk more whereas before was only able to communicate one or two words. Progress notes dated 8/23/24, indicated R19 had a change in condition; was verbally unresponsive, urine was cloudy, pus filled and odorous. A provider and family member were notified and R19 was sent to the hospital via ambulance at 5:03 p.m. On 8/30/24, R19 returned to the facility. During an interview on 11/5/24 at 3:41 p.m., in her office, the administrator provided a copy of R19's bed hold dated 8/23/24, and a form that was sent to the ombudsman to notify him/her of transfer to the hospital. The administrator stated she would check with social services to determine if they provided residents and/or resident representatives with written notice of transfer. Via electronic communication on 11/6/24 at 12:28 p.m., the administrator indicated no written notice of transfer was provided to R19 and/or her resident representative. A Transfer or Discharge, Facility Initiated, policy dated 10/22, included: - Resident whoa re sent emergently to an acute care setting such as a hospital are permitted to return to the facility. - -Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident; the residents health improves sufficiently to allow a more immediate transfer or discharge; an immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. - Notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care ombudsman when practicable.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245635	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER ST JOHNS ON FOUNTAIN LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments	E 000			
	On 11/4/24 through 11/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 11/4/24 through 11/6/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed with NO deficiencies cited: H56359915C (MN102180) and H56351201C (MN108010).				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.				
	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.				
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580			12/12/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/06/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580 SS=D	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580			

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F 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of neck pain following a fall for 1 of 1 resident (R25) reviewed for accidents. Findings include: R25's facesheet printed 11/6/24, included diagnoses including Parkinsonism (condition that affects movement), pneumonia, atrial fibrillation (the heart's upper chambers beat chaotically and irregularly), displaced fracture of second cervical vertebra (broken bone in the neck region of the spine) and fracture of nasal bones. R25's significant change Minimum Data Set (MDS) assessment dated 8/13/24, included a brief interview for mental status score of 15 indicating intact cognition, uses walker and wheelchair and is dependent for toileting, dressing, and substantial/maximal help for transfers. R25 does not walk. R25 had one fall with major injury. R25's care plan undated, indicated the resident required extensive assistance assist of one and a	F 580	F000 Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws. F580 Notify of Changes (Injury/Degrade/Room, Etc.) Fax was sent to primary care provider for R25's fall on August 3, 2024, shortly after the fall occurred. On-call physicians were notified on August 4, 2024, and resident sent to ER. All like residents were reviewed on or before December 10, 2024 with 3 additional found. Notification to provider occurred on or before December 10, 2024.		

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F 580	Continued From page 3 gait belt to stand pivot transfer and wears a cervical (C)-collar related to neck fracture per physicians order. R25 is at risk for falls and injuries related to impaired balance and mobility, cognitive impairments and exhibits poor safety awareness and self transfers. Interventions for fall included administer medications, supplements as ordered, complete fall risk assessment on admission and as needed per facility policy, follow facility fall protocol, pharmacy consult to evaluate medications, sign in room reminding to ask for assistance, dycem (non slip material) to wheel chair, reacher, autolock brakes added to wheelchair, chair at bedside when in bed and wheelchair bag for storage. R25's current physician orders included: C-collar on at all times dated 8/14/24. On interview and observation 11/4/24 at 3:24 p.m., R25 was sitting in his wheelchair in his room. R25 had on a rigid C-collar on his neck. R25 stated it seems like a long time ago when he fell and broke neck but still has to wear C-collar. R25 indicated he was reaching for something and fell out of his chair. R25 denied any pain currently. A Post Fall Evaluation dated 8/3/24 at 11:43 a.m., no identifier present who completed the form, indicated R25 had an unwitnessed fall at 11:00 a.m. in his room reaching for an item. R25 had an abrasion to his mid forehead 4 centimeters (cm) by 2 cm and a skin tear to left back of hand. The provider was notified by fax. Wheelchair was unlocked and call light was on when resident found. R25 stated he was reaching for paper on the floor that was out of reach. R25 complained of some mild pain in his right foot.	F 580	All residents have the potential to be affected by this practice. Fall Assessing and Reporting policy and procedure was reviewed on November 13, 2024, and again on December 4, 2024, by DON, Nurse Managers, Staff Devel/IP nurse, and administrator. Updates were made that states to notify the provider, during off hours, notify on-call provider; if there is head or neck pain call 911. Training and education with licensed nurses occurred on or before December 12, 2024. An audit will be conducted on all changes in condition daily, M-F for 4 weeks, 1x weekly for 4 weeks, and monthly thereafter for one month to ensure the appropriate communication is occurring with provider. Results will be reported to QAPI.		

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F 580	Continued From page 4 Communication was sent via fax to physician including fall with abrasion to mid forehead 4 cm by 2 cm left open to air. Skin tear to the back of left hand cleansed with normal saline and band aid applied. Resident was reaching for a piece of paper on the floor and fell forward out of wheelchair unwitnessed. Please note fall with head protocol being followed, abrasion to mid forehead left open to air, and is it okay to cleanse skin tear to back of left hand daily with normal saline and apply Band-Aid? R25's nursing progress note by licensed practical nurse (LPN)-H dated 8/3/24 at 3:36 p.m., indicated monitoring resident post fall with head abrasion frontal lobe (forehead). At 3:15 p.m., R25 is complaining of neck pain sitting in wheelchair at the time of examination. Declined tylenol for pain. Gently palpitated cervical spine; resident had no pain with palpitation. Resident unable/unwilling to elaborate on pain. Did confirm it was new since fall. Had no complaints of neck pain on prior vital sign checks or that was noted by the nursing assistants. Checked all four extremities for numbness and tingling and R25 denied. Demonstrated movement and strength; equal. Palpitated muscles on sides of neck and did not complain of pain. Offered cool pack and R25 declined. Offered two times very clearly to have him sent to the emergency room for evaluation of neck fracture due to hitting his head on floor. He said no both times. Stated "I just want to lay down." Staff assisted him to lay down and he did complain of pain when doing this even when his head was put back up at 45 degrees. Continue to monitor and offer pain relief. R25's nursing progress note by LPN-H on 8/3/24 at 4:43 p.m., indicated cool packs were applied to	F 580			

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F 580	Continued From page 5 cervical spine for complaints of pain post fall. See previous notes. R25's nursing progress note by LPN-H on 8/3/24 at 5:22 p.m., indicated resident continue to state his neck is hurting; explained it may be a muscle sprain from his fall. Has only been 45 minutes since Tylenol was given. Continue to monitor and treat pain with as needed treatments. R25's nursing progress note by LPN-H on 8/3/24 at 10:48 p.m., included following up on neck pain from fall at 11 a.m. today. Resident complaining of more severe pain when he is rolling in bed or with bed mobility. States minimal pain when still. Gave cool pack at 10:05 p.m. for 20 minutes to upper back/lower neck. Resident indicated it helped some. Tylenol last given at 4:40 p.m. Does not have any other as needed pain relieving treatments available. Still denies any pain/numbness/tingling in all externalities. Passed on to night shift to give as needed extra strength Tylenol when able to do so. R25's nursing progress note by registered nurse (RN)-G on 8/4/24 at 7:20 a.m., included resident slept poorly. States has "worse pain" to posterior (back) of neck, especially with repositioning/turning to sides when changing undergarments. Swelling and hematoma (collection of blood outside of blood vessels due to injury or trauma) to forehead/frontal lob 4 x 2 cm x 0.5 cm depth. Arouses easily and is alert and oriented to self and place. Hand grasps are equal, speech clear. Concern with need for imaging (X-rays) so notified on call physician at 3:10 a.m., who gave order to transfer resident to the emergency department (ER). Notified family member at 3:00 a.m., who gave permission to	F 580			

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F 580	Continued From page 6 send. Ambulance called at 3:17 a.m. and transported at 3:35 a.m. An ED note 8/4/24 at 9:33 a.m., included diagnosis of fall with abrasion to scalp, fracture of second cervical vertebrae, fracture of orbit (upper face bone), nasal fracture, also with frontal bone fracture (forehead region of the skull). R25's nursing progress note 8/4/24 at 11:15 a.m., indicated R25 was sent to ER for evaluation due to complaints of neck pain on night shift. R25 just returned now, wearing C-collar to be kept on at all times for 14 days. R25 was started on Augmentin (antibiotic) for pneumonia. On interview 11/5/24 at 2:36 p.m., medical doctor (MD)-F, R25's doctor, indicated a fall with neck pain requires evaluation in the ED as soon as possible. Even if the neck pain onset was hours after the fall, the provider should have been notified immediately when he started complaining of neck pain. MD-F stated R25 could have lost mobility or even his life by delaying the immobilization of his neck. On interview 11/5/24 at 3:27 p.m., licensed practical nurse (LPN)-D indicated if someone started complaining of neck pain after hitting their head he would notify the provider immediately and transfer to the ER even if the neck pain wasn't initially present. On interview 11/5/24 at 3:33 p.m., LPN-E indicated the provider should be notified right away if a resident fell and then later complains of neck pain especially if the resident hit their head. On interview 11/5/24 at 3:44 p.m., LPN-F	F 580			

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F 580	Continued From page 7 indicated any time a resident complains of neck pain after a fall, the physician should be notified and the resident sent to the ED. On interview 11/5/24 at 4:18 p.m., registered nurse (RN)-E, also identified as nurse manager, indicated the provider was initially contacted when R25 fell, but confirmed the nurse should have notified the physician again when R25 began complaining of neck pain. RN-E added LPN-H did offer to send him to the ED but he refused. On interview 11/6/24 at 10:40 a.m., the director of nursing (DON) after reviewing R25's medical record confirmed the provider should have been notified when R25 began having neck pain. A policy on notification to physician was requested but not received.	F 580			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686			12/12/24

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F 686	Continued From page 8 Based on observation, interview, and document review the facility failed to ensure weekly comprehensive skin assessments with measurements were completed for 1 of 3 residents (R59) reviewed for pressure ulcers. Findings include: R59's significant change in status Minimum Data Set (MDS) assessment dated 10/19/24, indicated cognitively intact, required substantial/maximal assistance with toileting, transfers, shower/bathe, dressing, personal hygiene, utilized a wheelchair, frequently incontinent of urine and bowel, diagnoses included: type one diabetes, cancer, hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), chronic kidney disease; at risk for developing pressure ulcers, two unstageable pressure injuries presenting as deep tissue injury (full thickness skin and tissue loss), treatments included: pressure reducing device for chair and bed and pressure ulcer care. R59's care plan printed 11/6/24, indicated stage two pressure injury (partial-thickness skin loss) on both left and right heels, interventions included: follow facility protocols for treatment of injury, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (medical doctor), pressure relieving/reducing mattress, pressure relieving/reducing chair, cushion to protect the skin while in bed and sitting in chair, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.	F 686	R59 had comprehensive skin check completed on November 5, 2024. All like residents were reviewed for skin risk on or before by November 26, 2024, no new findings. Pressure injury and skin assessment policy and procedure were reviewed on November 13, 2024, by DON and nurse managers to reflect updated practices due to new electronic clinical software and assessments. Additional training on wound care being done with nursing team randomly throughout nurse manager's shift. Training and education with licensed nursing staff was completed on or before December 12, 2024. Skin checks are being reviewed daily (M-F) for completion by nurse managers to ensure appropriate follow-up by floor staff. An audit will be conducted on all required skin checks daily M-F for 4 weeks, 1x weekly for 4 weeks, and monthly thereafter for one month to ensure the appropriate skin checks and assessments are being completed. Results reported to QAPI.		

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F 686	Continued From page 9 R59's document titled skin only evaluation dated 9/12/24, did not indicate concerns or skin abnormatilities of R59's heels or feet. R59's document titled Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 10/3/24, indicated R59 was not at risk for developing pressure ulcers. R59's progress notes indicated : 10/10/24 at 4:12 p.m., licensed practical nurse (LPN)-A indicated R59 has pressure ulcers on both heels, .. sent for air mattress and pillow under both feet to elevate heels. 10/24/2024 at 2:59 p.m., LPN-C indicated open areas bilateral heels, diabetic, Rt (right) 2 cm (centimeters) x 4 cm, Lt (left) 4 cm x 3.5 cm, no drainage, Mepilex (absorbent foam dressing) applied, recommendations: to be assessed by wound nurse. 10/28/24 at 4:39 p.m., LPN-B indicated recommendations from nurse practitioner (NP)-A, known as the wound nurse, wound one and two: left posterior heel and right medial heel, cleanse wound, and peri wound with ns (normal saline), pat dry, apply collagen sheet, cover with dry bordered dressing, agreed, and signed by physician assistant (PA)-B. 11/05/2024 4:11 p.m., registered nurse (RN)-A indicated R59 and POA (power of attorney) requesting a wound clinic referral to her wound on the right heel. SBAR (situation, background, assessment, and recommendation/request communication) filled out for MD/NP (medical	F 686			

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F 686	Continued From page 10 doctor/nurse practitioner) to advise/address R59's documents titled Skin Check indicated: 10/10/2024 at 4:00 p.m., LPN-A new skin issue left heel, pressure ulcer / injury, acquired in-house, not painful, length: 4 cm width 4.5 cm depth 0 cm; right heel issue type stage two pressure ulcer / injury - partial thickness skin loss with exposed dermis. wound acquired in-house, wound is new, no signs and symptoms of infection, not painful, length 3 cm width 2.5 cm depth 0 cm, additional care: heel suspension / protection device. 10/12/2024 at 1:14 a.m., RN-A indicated left heel pressure ulcer / injury, wound acquired in-house, not painful, length 4 cm width 4.5 cm depth 0 cm, right heel pressure ulcer / injury, stage two partial thickness skin loss with exposed dermis, wound acquired in-house, length 3 cm width 2.5 cm depth 0 cm, heel suspension / protection, additional care: air flow pad, skin loss with exposed dermis (middle layer of the skin), boggy, additional care: heel suspension/ protection device, air flow pad. 10/24/2024 at 2:41 p.m., LPN-C indicated left heel pressure ulcer / injury, unstageable pressure injuries presenting as deep tissue injury, wound acquired in-house, unknown how long the wound has been present, no signs and symptoms of infection, painful, 4 cm length, 3.5 cm width, 0.1 cm depth, granulation (development of new tissue): 20%, slough (shedding dead surface cells from the skin): 80%, surrounding tissue: dry / flaky, cool, dressing saturation: none, cleansing solution: normal saline, primary dressing: hydrocolloid (moisture-retentive dressings), right	F 686			

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F 686	Continued From page 11 heel pressure ulcer / injury unstageable pressure injuries presenting as deep tissue injury, acquired in-house, unknown how long the wound has been present, no signs and symptoms of infection, painful: yes, medicate prior dressing change, 2 cm length, 4 cm width, 0.1 cm, cleansing solution: normal saline, primary dressing: foam, additional care: heel suspension / protection device. 11/05/2024 at 4:37 p.m., RN-C, known as the nurse manager, indicated skin is pale in color, skin is fragile, normal skin turgor, medial left heel, stage two pressure ulcer / injury, partial thickness skin loss with exposed dermis, wound acquired in-house on 10/10/2024, no signs and symptoms of infection, painful with dressing change, medicate prior dressing change, length 4.8 cm, width 4 cm, depth 0.2 cm, epithelial: 20%, slough: 20%, eschar: 60%, moderate sanguineous exudate, surrounding tissue: maceration; stage two right heel pressure ulcer / injury partial thickness skin loss with exposed dermis wound acquired in-house 10/10/2024, no signs and symptoms of infection, painful at dressing change, length 1.5 cm, width 1.5 cm, depth 0.2 cm, epithelial: 50%. granulation: 30%, slough: 20%, peri wound: rolled edge surrounding tissue: maceration. edema: no swelling or edema, skin issue education: change clothing / briefs, turn every two hours. R59's visit report document dated 10/25/24, RN-D, wound care nurse, indicated wound one: left, posterior heel is a stage two pressure injury/pressure ulcer acquired on 10/24/24, and has received a status of not healed, initial wound encounter measurements are 4 cm length x 3.5 cm width x 0.1 cm depth, with an area of 14 sq (square) cm and a volume of 1.4 cubic cm			F 686			

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F 686	Continued From page 12 moderate amount of drainage, wound bed has 1-25 %, granulation, 76-100% epithelialization, no slough and no eschar present, DTI (deep tissue injury) present, autolytic debridement performed; wound two right, medial heel is a stage two pressure injury pressure ulcer acquired on 10/24/2024, and has received a status of not healed, wound encounter measurements are 2 cm length x 4 cm width x 0.1 cm depth, with an area of 8 sq cm and a volume of 0.8 cubic cm, moderate amount of drainage noted, wound bed has 26-50%, granulation, 26-50% slough, 1-25% epithelialization; wound #1 - left, posterior heel - pressure ulcer cover wound with bordered super absorbent 3.5" (inches) x 4" (inches) every day for 25 days; wound #2 - right, medial heel - pressure ulcer cover wound with bordered super absorbent 3.5" x 4" every day for 25 days apply wound with collagen sheet 2" x 2" every day for 25 days. R59's treatment administration record (TAR), dated 10/1/24-10/31/24, skin check on bath day: document any bruise, rash, or open area. On 10/17/24, the TAR documentation indicated a "5", which indicated hold/see progress notes. R59's progress notes failed to indicate a documented comprehensive skin check. R59's TAR dated 11/1/24-11/30/24, indicated weekly wound assessment B/L(bilateral lower heels every day shift every Saturday with a start date of 11/2/24. R59's TAR date 11/2/24, was blank and documentation in R59's chart of a weekly wound assessment was found for 11/2/24. On 11/5/24 at 8:34 a.m., R59 was lying on an air mattress in bed on and positioned on her back, with foam cushioned boots. R59 stated she was a	F 686			

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F 686	Continued From page 13 diabetic and had ongoing problems with her feet, had an amputated toe, and recently broke her ankle prior to coming to the facility. R59 stated she had sores on her heels due to diabetes. R59 verified she wore cushioned boots in bed and while in the wheelchair, and staff repositioned her in bed. On 11/5/24 at 8:34 a.m., nursing assistant (NA)-A and NA-B stated R59 always wore cushioned boots. NA-A stated R59's heels were also floated while in bed. NA-A and NA-B were observed to provide morning cares for resident and removed boots and when morning cares were complete cushioned boots were replaced and R59 was transferred to the wheelchair. NA-A stated the NA's were responsible to inform the nurse when residents had changes in the skin. On 11/5/24 at 11:24 a.m., RN-C, known as the nurse manager, confirmed R59 had bilateral heel pressure ulcers acquired at the facility. RN-C stated the heel ulcers were discovered on 10/10/24, and further stated R59 had a decline in health prior to admission to the facility. RN-C stated R59 at times would refuse position changes, and R59 would not want to get out of bed some days. RN-C stated interventions included cushioned boots and floating heels. RN-C confirmed a comprehensive skin assessment was not completed weekly as expected after 10/10/24, and stated the next weekly assessment was 10/24/24. RN-C stated R59's wound had not worsened and were unavoidable due to her decline in health, and refusal for repositioning. On 11/5/24 at 1:38 p.m., RN-D, facility consulting wound nurse, stated she came to the facility and			F 686			

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F 686	Continued From page 14 completed wound care on residents. RN-D stated weekly comprehensive skin checks were expected and documented by the facility. RN-D stated with R59's diagnoses, medications, and poor perfusion the pressure ulcers were most likely not avoidable. RN-D further stated without further diagnostic tests hard to determine if the wounds were pressure related or related to poor blood flow. RN-D stated due to comorbidities, decline in health and diet, put her at risk for skin breakdown. On 11/5/24 at 4:33 p.m., R59 was seated in a wheelchair at dining table with cushion boots on feet. On 11/6/24 at 9:26 a.m., the director of nursing (DON) and administrator stated weekly skin checks were expected and documented and confirmed the weekly skin check after 10/10/24, was not completed until 10/24/24. The DON stated pressure ulcers should be measurement weekly with a comprehensive assessment. The DON stated wounds were discussed during IDT (interdisciplinary team) meetings. The DON stated R59 was at risk for pressure related concerns due to her diagnoses. On 11/6/24 at 11:09 a.m., PA-C stated R59 was prone to skin break down due to comorbidities including diabetes, and stated the facility was expected to complete weekly comprehensive wound assessments that included measurements. On 11/06/24 at 11:38 a.m., LPN-B confirmed R59 had bilateral heel ulcers and confirmed weekly comprehensive skin assessments with measurements were expected weekly, and stated			F 686			

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F 686	Continued From page 15 she was aware that R59 had skin assessments that were not documented to include the measurements and comprehensive description. The facility Pressure Injury policy dated 9/2019, indicated: To provide appropriate assessment and prevention of pressure injuries, as well as receive the necessary treatment and services to promote healing, prevent infection and prevent any new pressure injuries from developing. Based on the resident's Comprehensive Skin Assessment, St John's will utilize prevention and assessment interventions to assure that a resident entering the center without pressure injuries does not develop a pressure injury unless the resident's individual clinical condition demonstrates that this was unavoidable, and this information will be documented in the medical record. Upon noticing a pressure injury, complete a Wound Assessment and Braden Scale in the EMAR under assessments. Add an order to complete a Wound Assessment in the EMAR weekly. Start interventions as ordered/needed. Notify PCP or in-house NP of new pressure injury. Notify family of new pressure injury. Notify dietary of new pressure injury. Consult PCP, in-house NP, Nurse Manager, visiting wound nurse or Wound Clinic as needed for treatment. Complete a new Wound Assessment Weekly. Document weekly and PRN in the Interdisciplinary Nursing notes on the size, drainage, odor, pain, surrounding tissue, and treatment. Review at IDT meetings. When area is fully healed, update Plan of Care, PCP, and document in the Interdisciplinary Nursing notes	F 686			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245635	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
NAME OF PROVIDER OR SUPPLIER ST JOHNS ON FOUNTAIN LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007		
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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		12/12/24	

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F 756	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to act upon the consultant pharmacist's recommendation for 2 of 5 residents (R55, R59) reviewed for unnecessary medications. Findings include: R59's significant change in status Minimum Data Set (MDS) assessment dated 10/19/24, indicated cognitively intact, required substantial/maximal assistance with toileting, transfers, shower/bathe, dressing, personal hygiene, utilized a wheelchair, frequently incontinent of urine and bowel, diagnoses included: type one diabetes cancer, hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), and chronic kidney disease. R59's document title Medication Regimen Review Report dated 9/21/24, consulting pharmacist (CP)-A indicated potential medication need: R59 with diabetes mellitus type one and CKD3 (chronic kidney disease stage 3) does not receive ACEI/ARB (angiotensin converting enzyme inhibitor and angiotensin receptor blocker therapy is a combination of two types of prescription medications that are commonly used to treat a variety of conditions therapy including chronic kidney disease), presence of albuminuria (sign of kidney disease and means that you have too much albumin in your urine) is unknown from records, no allergy/intolerance to ACEI/ARB noted in records. Recommendation: please follow-up on whether ACEI/ARB therapy is indicated for this individual. Order clarification: order for ASA (aspirin) 81 upon admission of			F 756	R55 and R59 consultant pharmacy recommendations were acted upon by DON on December 4, 2024. Primary care provider responded on December 10, 2024 with an emailed clarification on the recommendations. All like residents were reviewed from November 23, 2024 thru December 10, 2024. 10 residents found and need to be addressed by their next provider visit. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director (or the physician of record) or the administrator. All like residents have the potential to be impacted by this practice. Medication Regimen Review (MRR) policy and procedure was reviewed with DON, Administrator, and Pharmacy Consultant on December 6, 2024, with no changes made. Starting on December 9, 2024, MRRs will go to the nurse managers, DON, or designee for review, they will be printed off, and complete an SBAR, and attach it to the consultant pharmacist's recommendation by the time of the next routine visit, or prior if clinically indicated. Training and education were completed on or before December 12, 2024, with		

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F 756	Continued From page 18 8/12/24, no indication for use nor stop date if applicable. On 11/6/24 at 11:30 a.m. R59's paper chart was located in the nursing station and included the CP-A's recommendation dated 9/21/24. R59's provider and nursing orders were reviewed and lacked documentation the facility had addressed CP-A recommendations. On 11/6/24 at 11:48 a.m., registered nurse (RN)-C, known as the nurse manager stated CP-A emailed the director of nursing (DON) with resident pharmacy recommendations. RN-C stated she was not part of the pharmacy recommendations process, and confirmed R59's recommendation dated 9/21/24, was not addressed as expected. On 11/6/24 at 12:02 p.m., the director of nursing (DON) stated she received a monthly email from CP-A with resident's pharmacy and medication recommendations. The DON stated the email was forwarded to the health unit coordinator (HUC)-D who printed the recommendations and placed a hard copy of the pharmacy recommendation for the provider to address when next at the facility. The DON stated the provider was expected to address the pharmacy recommendations, and further stated she was responsible to ensure pharmacy recommendations were addressed. The DON confirmed R59's pharmacy recommendations dated 9/21/24, were not addressed as expected by the provider. R55's quarterly MDS assessment dated 10/18/24, indicated moderately impaired cognition, required maximal to moderate assistance with toileting,			F 756	nurse managers, health information manager (HIM), and health unit coordinators (HUCs) on MRR policy and procedure. An audit will be conducted weekly for 8 weeks, weekly for 4 weeks, and monthly thereafter for one month to ensure the drug regimen review is occurring based on criteria within facility policy. Results will be reported to QAPI.		

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F 756	Continued From page 19 transfers and walking. Medications included anticoagulant, antidepressant, diuretic, anticonvulsant, and hypoglycemic. Active diagnoses included fractures, atrial fibrillation, heart failure, anemia, hypertension, renal insufficiency, diabetes, and chronic obstructive pulmonary disease. No psychiatric/mood disorder was indicated including anxiety or depression. R55's Medication Regimen Review Report dated 6/24/24, CP-A indicated potential medication need: R55 is taking duloxetine (antianxiety, antidepressant medication) with indication of cognitive impairment as diagnosis, is inappropriate. Please link to an appropriate indication, or clarify with a provider if no indication for use has been issued. A progress note from pharmacy consultant dated 7/30/24, indicated medical record reviewed (MRR) with no concerns reported. A progress note from 9/10/24, included indication for duloxetine requested previously and this is second notice due to non-response. Inappropriate indication of cognitive impairment is currently linked to this agent. A progress note dated 10/20/24, included duloxetine inappropriate indication for use. This is 3rd notice issued. Administrative nursing staff emailed to ensure this is resolved. R55's provider orders last signed 10/23/24, by medical doctor (MD)-F, included duloxetine delayed release particles 30 mg one capsule one time a day for cognitive impairment. Initial order date of 6/5/24.	F 756			

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F 756	Continued From page 20 On interview 11/6/24 at 12:47 p.m., RN-C, known as the nurse manager stated she is not involved in pharmacy reviews and added the director of nursing and the health unit coordinator (HUC) is responsible for those. On interview 11/6/24 at 12:56 p.m., the DON indicated it is the responsibility of both nurse managers to get the pharmacy recommendations completed. The DON then clarified stating RN-C started her employment in August 2024 and hasn't been trained on pharmacy reviews yet. The DON stated the pharmacy recommendations are electronically mailed (email) to her. The DON stated she does remember getting an email about R55's duloxetine recommendations but had not acted on the recommendation at this time. On 11/6/24 at 12:05 p.m., a phone call was placed to CP-A and a voicemail was left and return phone call was not received from CP-A. Facility Medication Regimen Reviews policy dated 5/19, indicated: The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: medications ordered in excessive doses or without clinical indication; medication regimens that appear inconsistent with the	F 756			

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F 756	Continued From page 21 resident's stated preferences; duplicative therapies or omissions of ordered medications; inadequate monitoring for adverse consequences; potentially significant drug-drug or drug-food interactions; potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences; incorrect medications, administration times or dosage forms; or other medication errors, including those related to documentation. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: the resident's name; the name of the medication; the identified irregularity; and the pharmacist's recommendation. An "irregularity" refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences.	F 756			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812			12/12/24

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F 812	Continued From page 22 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain holding temperatures for hot foods of 135 degrees Fahrenheit or greater. In addition, the facility failed to ensure dietary staff followed appropriate infection control practices during food prep and meal service in the kitchen. This had the potential to affect 22 of 22 residents residing on the unit. Findings include: On 11/4/24 at 5:14 p.m., during observation, two baking sheets of cooked cheese quesadillas were sitting on the stove top, one tray completely covered, and one partially covered with aluminum foil. Surveyor asked cook (C)-A to re-temp the cheese quesadillas approximately five minutes after removing them from the oven and leaving one baking sheet partially uncovered. Cheese quesadillas were temped at 136 degrees Fahrenheit on initial removal from the oven and dropped to 127 degrees Fahrenheit on recheck. On 11/4/24 at 5:20 p.m., during interview with the			F 812	Assistant cook was educated on the hand hygiene policy on November 9, 2024. The Hand Hygiene policy and procedure was reviewed on November 7, 2024, by the infection preventionist with no changes made. All dining services staff received hand hygiene education starting November 9, 2024, and was completed by November 19, 2024. An audit was initiated on November 13, 2024, to ensure staff comply with hand hygiene policy daily, M-F, for one month, 1x weekly for 1 month, and monthly thereafter for one month with results being reported to QAPI. All residents have the potential to be impacted by this practice Food and holding temperatures policy and		

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F 812	Continued From page 23 culinary services manager (CSM) stated that she would not expect the quesadillas to be out of the oven and cooling down partially uncovered. The cheese quesadillas should have been in the oven on warm to hold the appropriate temperature for the resident's food. The culinary services manager stated the cheese quesadilla's will now need to be warmed up in the microwave before the residents receive their meal. On 11/4/24 at 5:22 p.m., during interview, C-A stated the quesadillas should have been kept in the oven on warm and recognized the potential for the quesadillas to cool down by leaving them on stove top partially uncovered. On 11/5/24 at 9:02 a.m., during observation, C-B prepared bacon for breakfast and placed it in a frying pan on top of the stove. The frying pan of bacon was kept on the warm burner via stove top without a lid/cover. On 11/5/24 at 9:05 a.m., during observation, C-B took the bacon temperature while it was on the warm burner (already cooked) and the holding temperature was 119.9 degrees Fahrenheit. On 11/6/24 at 11:40 a.m., during interview, the CSM stated foods that are hot need to be held at 165 degrees Fahrenheit and reheated to 165 degrees Fahrenheit. After looking on a cell phone, the CSM stated the quesadillas and bacon should have been held at 135 degrees Fahrenheit and acknowledged the foods prepared in the 3rd floor kitchen were not at adequate holding temperatures despite the food being cooked. Facility Food Temperatures policy undated,	F 812	procedure were reviewed on November 8, 2024, by the director of dining services, the consultant dietician, and CEO/Administrator. No changes were made. All dining services staff received food and holding temperatures education starting November 9, 2024, and was completed by November 19, 2024. Food and holding temperatures log sheets were updated to include this information for staff on or before November 19, 2024. An audit was initiated on November 13, 2024, to ensure staff understand and comply with food and holding temperatures daily, M-F, for one month, 1x weekly for 1 month, and monthly thereafter for one month with results being reported to QAPI.		

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F 812	Continued From page 24 indicated all hot food items must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Hot food items may not fall below 135 degrees Fahrenheit after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit prior to serving. Infection Control On 11/4/24 at 5:16 p.m., during observation, C-A was cutting a cheese quesadilla with a pizza cutter, initially C-A did not have gloves on. After touching the quesadillas with bare hands, C-A realized gloves were needed and stopped what C-A was doing to don gloves before continuing food preparation. The cheese quesadilla was not discarded. On 11/4/24 at 5:25 p.m., during observation, C-A placed fingers inside of a soup bowl, where food had the potential to be in contact with the same surface, removed a quesadilla from the microwave, and proceeded to cut the quesadilla without washing hands and/or donning gloves. On 11/4/24 at 5:29 p.m., C-A and another staff member collided in the kitchen. This incident caused C-A to drop a glass bowl of peaches. C-A proceeded to sweep up the broken glass bowl and peaches with a broom and dustpan, grabbed a cardboard box out of the garbage can in the kitchen and placed it on the floor, dumped the broken glass and peaches from the dustpan into a clear garbage bag and then placed the garbage bag in the cardboard box. Further, C-A placed the cardboard box (with broken glass and peaches)			F 812			

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F 812	Continued From page 25 on the countertop next to the sink. C-A then proceeded to place hands on the serving counters and did not wash them or use alcohol-based hand sanitizer. Finally, C-A took the cardboard box of broken glass and peaches to the appropriate garbage. C-A did not wash hands after bringing the cardboard box to the garbage and proceeded to take a clean skillet pan out of the cupboard, put the aluminum foil back over the quesadillas, and placed the quesadillas back into the oven on warm. On 11/4/24 at 7:30 p.m., during interview C-A stated hands should have been washed after removing the garbage from the kitchen and before preparing food/removing pans. On 11/6/24 10:36 a.m., during interview the director of nursing (DON) stated staff need to re-educated on infection control immediately. The DON further stated infection control concerns have the potential to affect all residents living on that unit. On 11/6/24 11:44 a.m., during interview the CSM stated education has been started for the dietary staff. Facility Hand Hygiene policy undated, indicated hand hygiene is the most important single procedure for preventing the spread of infection. Hand hygiene is known to reduce patient morbidity and mortality from healthcare acquired infections. Hand washing with soap and water whenever hands are visibly dirty, before eating, and after using the restroom. The facility's hand hygiene policy also indicated general indications for alcohol-based hand sanitizer that include after touching a resident or resident's immediate	F 812			

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F 812	Continued From page 26	F 812			
F 880 SS=F	environment, contaminated surfaced, and immediately after glove removal. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		12/12/24	

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F 880	Continued From page 27 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper infection control practices were followed for 1 of 1 resident (R54) when his urinary drainage bag was observed laying on the floor. Further, loose, and contaminated laundry was observed having been sent down the laundry chute without being secured in a laundry/plastic			F 880	R54's urinary bag was immediately picked up off the floor on November 6, 2024. DON identified residents that had indwelling catheters to investigate urinary bag placement. A daily audit was initiated		

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F 880	Continued From page 28 bag. This had the potential to affect all 68 residents who resided in the facility. Findings include: R54's facesheet printed on 11/6/24, included diagnoses of dementia, benign prostatic hyperplasia (an enlarged prostate gland that causes urinary difficulty), and retention of urine. R54's quarterly Minimum Data Set (MDS) assessment dated 8/15/24, indicated R54's BIMS (brief interview for mental status) score was 99 indicating R54 could not complete the interview. R54 had clear speech, could usually understand, and be understood. R54 had an indwelling urinary catheter. R54 was dependent on staff for activities of daily living. R54's physician orders dated 8/22/24, included urinary catheter: 16F (French) 10 cc (cubic centimeter) balloon for BPH (benign prostatic hyperplasia) with obstruction and urinary retention. R54's care plan dated 8/22/24, indicated R54 had a foley (a type of urinary catheter) indwelling catheter related to BPH with obstruction, and to connect to leg bag during the day and gravity drainage bag at night. Position catheter bag and tubing below the level of the bladder and away from entrance room door. During an observation on 11/6/24 at 8:58 a.m., R54 was in bed with his eyes closed. His entire urinary catheter bag was laying on the carpeted floor next to his bed. During an observation and interview on 11/6/24 at			F 880	on November 7, 2024, to monitor this deficient practice. All like residents have the potential to be affected by this practice. Signage was placed in laundry chute rooms on December 3, 2024, to clarify that linens need to be bagged before being thrown down the chute. Infection waste management, soiled linen handling, transportation policy and procedures were reviewed with no changes necessary on November 19, 2024, by nurse managers, infection preventionist, DON, and Administrator. Training and education with nurses, C.N.A's, laundry staff, and CA's specifically related to bagging dirty linen and to not leave urinary bags on the floor on or before December 12, 2024. Infection control policy and procedure was reviewed by nurse managers, infection preventionist, DON, and Administrator with no changes necessary on November 19, 2024. A daily audit was initiated on November 7, 2024, M-F for 4 weeks, 1x weekly for 4 weeks, and 1x monthly, by the DON or designee, to ensure no urinary bags are being left on the floor and linens are bagged before being thrown down the chute. Results will be reported to QAPI.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 29 9:19 a.m., the catheter bag was still on floor after licensed practical nurse (LPN)-G exited room after giving R54 medications. Together with LPN-G, returned to R54's room. When asked if it was acceptable to have the catheter bag laying on the floor, LPN-G replied, "I wondered that too" and "I don't think so." LPN-G donned gloves and hooked the catheter bag to the bed frame. LPN-G did not know who placed the bag on the floor and stated she found it in that location when she went into the room to give R54 his medications. LPN-G stated leaving the catheter bag on the floor could cause bacteria to get in the system and cause a UTI (urinary tract infection). During an interview on 11/6/24 at 10:03 a.m., registered nurse (RN)-F who was also the infection preventionist and staff development nurse, stated nursing staff were trained on orientation to make sure urinary catheter bags were not placed on the floor. RN-F stated the catheter bag could not rest on the floor or lay on the floor as bacteria could enter the port and migrate to the resident causing a UTI. During an interview on 11/6/24 at 11:14 a.m., RN-C who was also a nurse manager, stated staff were expected to hang the catheter bag on the bed frame and not allow it to rest on or lay on the floor; doing so could result in an infection. During an interview on 11/6/24, at 12:42 p.m., the director of nursing (DON) and the administrator were informed of findings. The DON stated catheter bags were never to be placed on the floor and staff had been trained to hang the bag on the bed frame or other surface to prevent that from occurring. The DON acknowledged a catheter bag laying on the floor could result in a			F 880			

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F 880	Continued From page 30 UTI to the resident. Facility Catheter Care (Indwelling) policy with revised date of 3/22, indicated the purpose of the policy was to prevent infection. The policy did not include proper positioning of a urinary drainage bag and/or to keep the bag off the floor. LAUNDRY During an interview on 11/5/24 at 8:51 a.m., laundry aide (LA)-B stated resident linens were sent to the basement via a laundry chute located on each floor. Resident's personal clothing were done in unit laundry rooms. During an observation on 11/6/24 at 7:38 a.m., in the basement, the small room where laundry was deposited via laundry chutes from three floors was observed. The room had two yellow carts on wheels, positioned side by side. The carts were full of plastic bags of linen. In addition to the plastic bags, were loose towels and cloth gowns. On the floor were small pieces of maroon colored fabric resembling napkins. During a telephone interview on 11/6/24 at 8:06 a.m., facilitated by environmental services director (EVS)-H, laundry coordinator (LC)-H stated linens placed down the chute should be bagged. During an observation on 11/6/24 at 8:09 a.m., with EVS-H, together observed the laundry chute room. The cloth napkins had been picked up off the floor and were in one of the carts. EVS-H acknowledged the loose towels and gowns in the carts, along with the plastic bagged linens.	F 880			

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F 880	Continued From page 31 During an interview on 11/6/24 at 8:21 a.m., LA-B admitted staff did not always bag the linen - they were supposed to but were probably in a hurry and just tossed them down the chute. LA-B stated she usually saw loose towels, gowns, and washcloths; blankets and sheets were usually bagged. During an observation on 11/6/24 at 8:26 a.m., observed linen and garbage chutes on third floor across from the service elevator. There was no signage to inform staff not to place loose laundry down the chute. During an interview on 11/6/24 at 8:30 a.m., community assistant (CA)-C stated she threw loose linen, like towels down the laundry chute, adding that linen only needed to be bagged if there was biohazard or fecal material on them. During an interview on 11/6/24 at 9:14 a.m., CA-D stated linen should be placed in a plastic bag first before putting it down the chute, adding she was aware that sometimes staff threw laundry down the chute that wasn't bagged. During an interview 11/6/24 at 10:02 a.m., RN-F, who was also the infection preventionist, was informed of findings and stated staff were not supposed to throw loose linen down the laundry chute in order to prevent the potential spread of infection. During an interview on 11/6/24 at 12:42 p.m., the director of nursing (DON) and administrator were informed of findings. The DON stated staff were aware to put linen in a plastic bag first before putting it down the chute; that it was an infection control concern if staff were carrying			F 880			

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F 880	Continued From page 32 contaminated linen against their uniform. The DON stated laundry staff usually informed her when loose linens were being sent down the chute. Facility Soiled Linen Handling and Transportation policy dated 1/2020, indicated the purpose was to prevent contamination of laundry personnel, surfaces, and residents while handling soiled linens. Soiled linens were to be collected and transported in a sealed plastic bag to prevent spread of contaminants. The policy did not include procedure for placing soiled linen down the chute.	F 880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/06/2024. At the time of this survey, ST JOHNS ON FOUNTAIN LAKE found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

12/06/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST JOHNS ON FOUNTAIN LAKE is a 3-story building with partial basement. The original building was constructed in 2014, a three-story building with a partial basement and was determined to be of Type II (111) construction.			K 000			

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K 000	Continued From page 2	K 000			
K 271 SS=E	The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in resident rooms, corridors, and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 84 beds and had a census of 69 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by: Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide approved discharge walking surfaces as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.1.6, 7.1.7. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that the 1st FL -stairwell D4 (DC2) exit sidewalk exhibited a	K 271	1st FL-stairwell D4 (DC2) trip and fall hazard was corrected on 12/5/2024 by blocking tripping hazard with a safety cone. All other FL 1st Floor entrances and exits were reviewed on or before 12/5/2024, if there was a trip hazard, it was blocked off by a safety cone. An audit will be conducted weekly for 12 weeks of each entrance and exit on 1st FL	12/12/24	

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K 271	Continued From page 3 slab-to-slab vertical displacement great-than one-half inch presenting a trip and fall hazard.	K 271	to ensure compliance with this requirement.	12/12/24	
K 353 SS=F	An interview with the Maintenance Director verified this deficient finding at the time of discovery. Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.3. This deficient finding could have a widespread impact on the residents within the	K 353	Results will be reported to QAPI.		

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K 353	Continued From page 4 facility. Findings include: On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by review of available documentation that no documentation was available to review to confirm that sprinkler quarterly testing had been completed for 2nd quarter - 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353			
K 355 SS=C	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2.4.1, 7.2.4.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by review of available documentation that no documentation was	K 355	Inspection of three fire extinguishers occurred on 11/21/2024. All fire extinguishers were being reviewed for up-to-date hang tags to ensure compliance on 11/6/2024. A monthly workorder is in place to ensure on-going compliance.	12/12/24	

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K 355	Continued From page 5 available to review associated to annual vendor inspection / findings / corrections. 2. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that hang-tags on fire extinguishers located in the Elevator Rooms (RM 26 & 29) had not been inspected by the vendor during annual inspection. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 355			
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to test and inspect the fire / smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.4.3, 8.5.4, NFPA 80 (2010 edition), Standards for Fire Doors and Other Protective Openings, section 5.2, 7.1. These deficient findings could have a widespread impact	K 374	Annual smoke barrier door testing was done in March of 2023, documents weren't found during Fire Marshall visit on November 6, 2024. Material was located after. All smoke barrier doors will be tested annually as required.	12/12/24	

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K 374	Continued From page 6 on the residents within the facility. Findings include: 1. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by review of available documentation that no documentation was available to review to confirm that annual fire / smoke barrier doors had been completed. 2. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that 3A-WD2 stairwell exit door did not close and seal the opening upon test. 3. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that 3rd FL smoke barrier doors exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. 4. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that the smoke barrier door at the dining room cross-over did not close and seal the opening upon test. 5. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that the smoke barrier door on 3rd FL (WD1) did not close and seal the opening upon test. 6. On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that the fire door assembly separating Building B (SNF) from Building D did not close and seal the opening upon test. An interview with the Maintenance Director verified	K 374	Stairwell door 3A-WD2 was corrected on 11/22/2024. 3rd FL smoke barrier doors were corrected on 11/19/2024. Smoke barrier door at dining room was tightened for secure closure on 11/19/2024. 3rd FL WD1 was corrected on 11/7/2024. Monthly door review is being done as required. Fire assembly doors separating Building B and D was corrected immediately 11/6/2024.		

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K 374 K 541 SS=F	Continued From page 7 these deficient findings at the time of discovery. Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain chute doors and safety measures of the trash chute systems per NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.2, 10.2.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 374 K 541	Lower-level trash room, sliding chute door had a repair done to ensure the closure spring was connected on 11/26/2024. No sliding trash chute doors are on-site.	12/12/24	

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K 541	Continued From page 8	K 541			
K 918 SS=F	On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation in the Lower-level Trash Room that the sliding chute door was not connected to closure spring(s). An interview with the Maintenance Director verified this deficient finding at the time of discovery. Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918			12/12/24

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K 918	Continued From page 9 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility did not test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, 6.4.4.2, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 8.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was presented to confirm that annual 2-hour load-bank testing had been completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Documentation of 2-hour load test was completed annually on 11/20/2024. Contract updated to include this annual test on 11/6/2024.		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		12/12/24	

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K 923	Continued From page 10 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.2.3, 11.6.5. This deficient finding could have a widespread impact on the residents within the	K 923	Lower-level med gas (O2) room was reorganized and clearly labeled to identify where to put empty and full containers on 11/19/2024. Training and education with nursing staff		

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K 923	Continued From page 11 facility. Findings include: On 11/06/2024 between 10:00 AM and 2:30 PM, it was revealed by observation that the Lower-level Med Gas (O2) Room had mixed storage of empty / full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 923	occurred on or before 12/11/2024 regarding keeping O2 separated within the guidelines as required. A weekly audit will be completed by EVS Director, or designee, to ensure on-going compliance with this requirement for 12 weeks. Results will be reported to QAPI.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 2, 2024

Administrator
St Johns On Fountain Lake
1771 Eagle View Circle
Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders
Event ID: G4HS11

Dear Administrator:

The above facility was surveyed on November 4, 2024 through November 6, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/06/2024
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/4/24 through 11/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

12/06/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H56359915C (MN102180) and H56351201C (MN108010). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000			

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265			12/12/24

Minnesota Department of Health

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of neck pain following a fall for 1 of 1 resident (R25) reviewed for accidents. Findings include: R25's facesheet printed 11/6/24, included diagnoses including Parkinsonism (condition that affects movement), pneumonia, atrial fibrillation (the heart's upper chambers beat chaotically and irregularly), displaced fracture of second cervical vertebra (broken bone in the neck region of the spine) and fracture of nasal bones. R25's significant change Minimum Data Set (MDS) assessment dated 8/13/24, included a brief interview for mental status score of 15 indicating intact cognition, uses walker and wheelchair and is dependent for toileting, dressing, and substantial/maximal help for transfers. R25 does not walk. R25 had one fall with major injury. R25's care plan undated, indicated the resident required extensive assistance assist of one and a gait belt to stand pivot transfer and wears a cervical (C)-collar related to neck fracture per physicians order. R25 is at risk for falls and injuries related to impaired balance and mobility, cognitive impairments and exhibits poor safety	2 265	Corrected.		

Minnesota Department of Health

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2 265	Continued From page 4 awareness and self transfers. Interventions for fall included administer medications, supplements as ordered, complete fall risk assessment on admission and as needed per facility policy, follow facility fall protocol, pharmacy consult to evaluate medications, sign in room reminding to ask for assistance, dycem (non slip material) to wheel chair, reacher, autolock brakes added to wheelchair, chair at bedside when in bed and wheelchair bag for storage. R25's current physician orders included: C-collar on at all times dated 8/14/24. On interview and observation 11/4/24 at 3:24 p.m., R25 was sitting in his wheelchair in his room. R25 had on a rigid C-collar on his neck. R25 stated it seems like a long time ago when he fell and broke neck but still has to wear C-collar. R25 indicated he was reaching for something and fell out of his chair. R25 denied any pain currently. A Post Fall Evaluation dated 8/3/24 at 11:43 a.m., no identifier present who completed the form, indicated R25 had an unwitnessed fall at 11:00 a.m. in his room reaching for an item. R25 had an abrasion to his mid forehead 4 centimeters (cm) by 2 cm and a skin tear to left back of hand. The provider was notified by fax. Wheelchair was unlocked and call light was on when resident found. R25 stated he was reaching for paper on the floor that was out of reach. R25 complained of some mild pain in his right foot. Communication was sent via fax to physician including fall with abrasion to mid forehead 4 cm by 2 cm left open to air. Skin tear to the back of left hand cleansed with normal saline and band aid applied. Resident was reaching for a piece of paper on the floor and fell forward out of	2 265			

Minnesota Department of Health

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2 265	Continued From page 5 wheelchair unwitnessed. Please note fall with head protocol being followed, abrasion to mid forehead left open to air, and is it okay to cleanse skin tear to back of left hand daily with normal saline and apply Band-Aid? R25's nursing progress note by licensed practical nurse (LPN)-H dated 8/3/24 at 3:36 p.m., indicated monitoring resident post fall with head abrasion frontal lobe (forehead). At 3:15 p.m., R25 is complaining of neck pain sitting in wheelchair at the time of examination. Declined tylenol for pain. Gently palpitated cervical spine; resident had no pain with palpitation. Resident unable/unwilling to elaborate on pain. Did confirm it was new since fall. Had no complaints of neck pain on prior vital sign checks or that was noted by the nursing assistants. Checked all four extremities for numbness and tingling and R25 denied. Demonstrated movement and strength; equal. Palpitated muscles on sides of neck and did not complain of pain. Offered cool pack and R25 declined. Offered two times very clearly to have him sent to the emergency room for evaluation of neck fracture due to hitting his head on floor. He said no both times. Stated "I just want to lay down." Staff assisted him to lay down and he did complain of pain when doing this even when his head was put back up at 45 degrees. Continue to monitor and offer pain relief. R25's nursing progress note by LPN-H on 8/3/24 at 4:43 p.m., indicated cool packs were applied to cervical spine for complaints of pain post fall. See previous notes. R25's nursing progress note by LPN-H on 8/3/24 at 5:22 p.m., indicated resident continue to state his neck is hurting; explained it may be a muscle sprain from his fall. Has only been 45 minutes	2 265			

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2 265	Continued From page 6 since Tylenol was given. Continue to monitor and treat pain with as needed treatments. R25's nursing progress note by LPN-H on 8/3/24 at 10:48 p.m., included following up on neck pain from fall at 11 a.m. today. Resident complaining of more severe pain when he is rolling in bed or with bed mobility. States minimal pain when still. Gave cool pack at 10:05 p.m. for 20 minutes to upper back/lower neck. Resident indicated it helped some. Tylenol last given at 4:40 p.m. Does not have any other as needed pain relieving treatments available. Still denies any pain/numbness/tingling in all externalities. Passed on to night shift to give as needed extra strength Tylenol when able to do so. R25's nursing progress note by registered nurse (RN)-G on 8/4/24 at 7:20 a.m., included resident slept poorly. States has "worse pain" to posterior (back) of neck, especially with repositioning/turning to sides when changing undergarments. Swelling and hematoma (collection of blood outside of blood vessels due to injury or trauma) to forehead/frontal lob 4 x 2 cm x 0.5 cm depth. Arouses easily and is alert and oriented to self and place. Hand grasps are equal, speech clear. Concern with need for imaging (X-rays) so notified on call physician at 3:10 a.m., who gave order to transfer resident to the emergency department (ER). Notified family member at 3:00 a.m., who gave permission to send. Ambulance called at 3:17 a.m. and transported at 3:35 a.m. An ED note 8/4/24 at 9:33 a.m., included diagnosis of fall with abrasion to scalp, fracture of second cervical vertebrae, fracture of orbit (upper face bone), nasal fracture, also with frontal bone fracture (forehead region of the skull).	2 265			

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2 265	Continued From page 7 R25's nursing progress note 8/4/24 at 11:15 a.m., indicated R25 was sent to ER for evaluation due to complaints of neck pain on night shift. R25 just returned now, wearing C-collar to be kept on at all times for 14 days. R25 was started on Augmentin (antibiotic) for pneumonia. On interview 11/5/24 at 2:36 p.m., medical doctor (MD)-F, R25's doctor, indicated a fall with neck pain requires evaluation in the ED as soon as possible. Even if the neck pain onset was hours after the fall, the provider should have been notified immediately when he started complaining of neck pain. MD-F stated R25 could have lost mobility or even his life by delaying the immobilization of his neck. On interview 11/5/24 at 3:27 p.m., licensed practical nurse (LPN)-D indicated if someone started complaining of neck pain after hitting their head he would notify the provider immediately and transfer to the ER even if the neck pain wasn't initially present. On interview 11/5/24 at 3:33 p.m., LPN-E indicated the provider should be notified right away if a resident fell and then later complains of neck pain especially if the resident hit their head. On interview 11/5/24 at 3:44 p.m., LPN-F indicated any time a resident complains of neck pain after a fall, the physician should be notified and the resident sent to the ED. On interview 11/5/24 at 4:18 p.m., registered nurse (RN)-E, also identified as nurse manager, indicated the provider was initially contacted when R25 fell, but confirmed the nurse should have notified the physician again when R25 began	2 265			

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2 265	Continued From page 8 complaining of neck pain. RN-E added LPN-H did offer to send him to the ED but he refused. On interview 11/6/24 at 10:40 a.m., the director of nursing (DON) after reviewing R25's medical record confirmed the provider should have been notified when R25 began having neck pain. A policy on notification to physician was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement measure to ensure timely notification to the physician. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop	2 900			12/12/24

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2 900	Continued From page 9 pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure weekly comprehensive skin assessments with measurements were completed for 1 of 3 residents (R59) reviewed for pressure ulcers. Findings include: R59's significant change in status Minimum Data Set (MDS) assessment dated 10/19/24, indicated cognitively intact, required substantial/maximal assistance with toileting, transfers, shower/bathe, dressing, personal hygiene, utilized a wheelchair, frequently incontinent of urine and bowel, diagnoses included: type one diabetes, cancer, hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), chronic kidney disease; at risk for developing pressure ulcers, two unstageable pressure injuries presenting as deep tissue injury (full thickness skin and tissue loss), treatments included: pressure reducing device for chair and bed and pressure ulcer care. R59's care plan printed 11/6/24, indicated stage two pressure injury (partial-thickness skin loss) on both left and right heels, interventions included: follow facility protocols for treatment of	2 900	Corrected.		

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2 900	Continued From page 10 injury, monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, s/sx (signs/symptoms)of infection, maceration etc. to MD (medical doctor), pressure relieving/reducing mattress, pressure relieving/reducing chair, cushion to protect the skin while in bed and sitting in chair, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R59's document titled skin only evaluation dated 9/12/24, did not indicate concerns or skin abnormatilities of R59's heels or feet. R59's document titled Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 10/3/24, indicated R59 was not at risk for developing pressure ulcers. R59's progress notes indicated : 10/10/24 at 4:12 p.m., licensed practical nurse (LPN)-A indicated R59 has pressure ulcers on both heels, .. sent for air mattress and pillow under both feet to elevate heels. 10/24/2024 at 2:59 p.m., LPN-C indicated open areas bilateral heels, diabetic, Rt (right) 2 cm (centimeters) x 4 cm, Lt (left) 4 cm x 3.5 cm, no drainage, Mepilex (absorbent foam dressing) applied, recommendations: to be assessed by wound nurse. 10/28/24 at 4:39 p.m., LPN-B indicated recommendations from nurse practitioner (NP)-A, known as the wound nurse, wound one and two: left posterior heel and right medial heel, cleanse wound, and peri wound with ns (normal saline),	2 900			

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2 900	Continued From page 11 pat dry, apply collagen sheet, cover with dry bordered dressing, agreed, and signed by physician assistant (PA)-B. 11/05/2024 4:11 p.m., registered nurse (RN)-A indicated R59 and POA (power of attorney) requesting a wound clinic referral to her wound on the right heel. SBAR (situation, background, assessment, and recommendation/request communication) filled out for MD/NP (medical doctor/nurse practitioner) to advise/address R59's documents titled Skin Check indicated: 10/10/2024 at 4:00 p.m., LPN-A new skin issue left heel, pressure ulcer / injury, acquired in-house, not painful, length: 4 cm width 4.5 cm depth 0 cm; right heel issue type stage two pressure ulcer / injury - partial thickness skin loss with exposed dermis. wound acquired in-house, wound is new, no signs and symptoms of infection, not painful, length 3 cm width 2.5 cm depth 0 cm, additional care: heel suspension / protection device. 10/12/2024 at 1:14 a.m., RN-A indicated left heel pressure ulcer / injury, wound acquired in-house, not painful, length 4 cm width 4.5 cm depth 0 cm, right heel pressure ulcer / injury, stage two partial thickness skin loss with exposed dermis, wound acquired in-house, length 3 cm width 2.5 cm depth 0 cm, heel suspension / protection, additional care: air flow pad, skin loss with exposed dermis (middle layer of the skin), boggy, additional care: heel suspension/ protection device, air flow pad. 10/24/2024 at 2:41 p.m., LPN-C indicated left heel pressure ulcer / injury, unstageable pressure injuries presenting as deep tissue injury, wound	2 900			

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2 900	Continued From page 12 acquired in-house, unknown how long the wound has been present, no signs and symptoms of infection, painful, 4 cm length, 3.5 cm width, 0.1 cm depth, granulation (development of new tissue): 20%, slough (shedding dead surface cells from the skin): 80%, surrounding tissue: dry / flaky, cool, dressing saturation: none, cleansing solution: normal saline, primary dressing: hydrocolloid (moisture-retentive dressings), right heel pressure ulcer / injury unstageable pressure injuries presenting as deep tissue injury, acquired in-house, unknown how long the wound has been present, no signs and symptoms of infection, painful: yes, medicate prior dressing change, 2 cm length, 4 cm width, 0.1 cm, cleansing solution: normal saline, primary dressing: foam, additional care: heel suspension / protection device. 11/05/2024 at 4:37 p.m., RN-C, known as the nurse manager, indicated skin is pale in color, skin is fragile, normal skin turgor, medial left heel, stage two pressure ulcer / injury, partial thickness skin loss with exposed dermis, wound acquired in-house on 10/10/2024, no signs and symptoms of infection, painful with dressing change, medicate prior dressing change, length 4.8 cm, width 4 cm, depth 0.2 cm, epithelial: 20%, slough: 20%, eschar: 60%, moderate sanguineous exudate, surrounding tissue: maceration; stage two right heel pressure ulcer / injury partial thickness skin loss with exposed dermis wound acquired in-house 10/10/2024, no signs and symptoms of infection, painful at dressing change, length 1.5 cm, width 1.5 cm, depth 0.2 cm, epithelial: 50%. granulation: 30%, slough: 20%, peri wound: rolled edge surrounding tissue: maceration. edema: no swelling or edema, skin issue education: change clothing / briefs, turn every two hours.	2 900			

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2 900	Continued From page 13 R59's visit report document dated 10/25/24, RN-D, wound care nurse, indicated wound one: left, posterior heel is a stage two pressure injury/pressure ulcer acquired on 10/24/24, and has received a status of not healed, initial wound encounter measurements are 4 cm length x 3.5 cm width x 0.1 cm depth, with an area of 14 sq (square) cm and a volume of 1.4 cubic cmmoderate amount of drainage, wound bed has 1-25 %, granulation, 76-100% epithelialization, no slough and no eschar present, DTI (deep tissue injury) present, autolytic debridement performed; wound two right, medial heel is a stage two pressure injury pressure ulcer acquired on 10/24/2024, and has received a status of not healed, wound encounter measurements are 2 cm length x 4 cm width x 0.1 cm depth, with an area of 8 sq cm and a volume of 0.8 cubic cm, moderate amount of drainage noted, wound bed has 26-50%, granulation, 26-50% slough, 1-25% epithelialization; wound #1 - left, posterior heel - pressure ulcer cover wound with bordered super absorbent 3.5" (inches) x 4" (inches) every day for 25 days; wound #2 - right, medial heel - pressure ulcer cover wound with bordered super absorbent 3.5" x 4" every day for 25 days apply wound with collagen sheet 2" x 2" every day for 25 days. R59's treatment administration record (TAR), dated 10/1/24-10/31/24, skin check on bath day: document any bruise, rash, or open area. On 10/17/24, the TAR documentation indicated a "5", which indicated hold/see progress notes. R59's progress notes failed to indicate a documented comprehensive skin check. R59's TAR dated 11/1/24-11/30/24, indicated weekly wound assessment B/L(bilateral lower heels every day shift every Saturday with a start	2 900			

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2 900	Continued From page 14 date of 11/2/24. R59's TAR date 11/2/24, was blank and documentation in R59's chart of a weekly wound assessment was found for 11/2/24. On 11/5/24 at 8:34 a.m., R59 was lying on an air mattress in bed on and positioned on her back, with foam cushioned boots. R59 stated she was a diabetic and had ongoing problems with her feet, had an amputated toe, and recently broke her ankle prior to coming to the facility. R59 stated she had sores on her heels due to diabetes. R59 verified she wore cushioned boots in bed and while in the wheelchair, and staff repositioned her in bed. On 11/5/24 at 8:34 a.m., nursing assistant (NA)-A and NA-B stated R59 always wore cushioned boots. NA-A stated R59's heels were also floated while in bed. NA-A and NA-B were observed to provide morning cares for resident and removed boots and when morning cares were complete cushioned boots were replaced and R59 was transferred to the wheelchair. NA-A stated the NA's were responsible to inform the nurse when residents had changes in the skin. On 11/5/24 at 11:24 a.m., RN-C, known as the nurse manager, confirmed R59 had bilateral heel pressure ulcers acquired at the facility. RN-C stated the heel ulcers were discovered on 10/10/24, and further stated R59 had a decline in health prior to admission to the facility. RN-C stated R59 at times would refuse position changes, and R59 would not want to get out of bed some days. RN-C stated interventions included cushioned boots and floating heels. RN-C confirmed a comprehensive skin assessment was not completed weekly as expected after 10/10/24, and stated the next weekly assessment was 10/24/24. RN-C stated	2 900			

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2 900	Continued From page 15 R59's wound had not worsened and were unavoidable due to her decline in health, and refusal for repositioning. On 11/5/24 at 1:38 p.m., RN-D, facility consulting wound nurse, stated she came to the facility and completed wound care on residents. RN-D stated weekly comprehensive skin checks were expected and documented by the facility. RN-D stated with R59's diagnoses, medications, and poor perfusion the pressure ulcers were most likely not avoidable. RN-D further stated without further diagnostic tests hard to determine if the wounds were pressure related or related to poor blood flow. RN-D stated due to comorbidities, decline in health and diet, put her at risk for skin breakdown. On 11/5/24 at 4:33 p.m., R59 was seated in a wheelchair at dining table with cushion boots on feet. On 11/6/24 at 9:26 a.m., the director of nursing (DON) and administrator stated weekly skin checks were expected and documented and confirmed the weekly skin check after 10/10/24, was not completed until 10/24/24. The DON stated pressure ulcers should be measurement weekly with a comprehensive assessment. The DON stated wounds were discussed during IDT (interdisciplinary team) meetings. The DON stated R59 was at risk for pressure related concerns due to her diagnoses. On 11/6/24 at 11:09 a.m., PA-C stated R59 was prone to skin break down due to comorbidities including diabetes, and stated the facility was expected to complete weekly comprehensive wound assessments that included measurements.	2 900			

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2 900	Continued From page 16 On 11/06/24 at 11:38 a.m., LPN-B confirmed R59 had bilateral heel ulcers and confirmed weekly comprehensive skin assessments with measurements were expected weekly, and stated she was aware that R59 had skin assessments that were not documented to include the measurements and comprehensive description. The facility Pressure Injury policy dated 9/2019, indicated: To provide appropriate assessment and prevention of pressure injuries, as well as receive the necessary treatment and services to promote healing, prevent infection and prevent any new pressure injuries from developing. Based on the resident's Comprehensive Skin Assessment, St John's will utilize prevention and assessment interventions to assure that a resident entering the center without pressure injuries does not develop a pressure injury unless the resident's individual clinical condition demonstrates that this was unavoidable, and this information will be documented in the medical record. Upon noticing a pressure injury, complete a Wound Assessment and Braden Scale in the EMAR under assessments. Add an order to complete a Wound Assessment in the EMAR weekly. Start interventions as ordered/needed. Notify PCP or in-house NP of new pressure injury. Notify family of new pressure injury. Notify dietary of new pressure injury. Consult PCP, in-house NP, Nurse Manager, visiting wound nurse or Wound Clinic as needed for treatment. Complete a new Wound Assessment Weekly. Document weekly and PRN in the Interdisciplinary Nursing notes on the size,	2 900			

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2 900	Continued From page 17 drainage, odor, pain, surrounding tissue, and treatment. Review at IDT meetings. When area is fully healed, update Plan of Care, PCP, and document in the Interdisciplinary Nursing notes SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee could conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900			
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper infection control practices	21375	Corrected.		12/12/24

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NAME OF PROVIDER OR SUPPLIER ST JOHNS ON FOUNTAIN LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 1771 EAGLE VIEW CIRCLE ALBERT LEA, MN 56007		
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21375	Continued From page 18 were followed for 1 of 1 resident (R54) when his urinary drainage bag was observed laying on the floor. Findings include: R54's facesheet printed on 11/6/24, included diagnoses of dementia, benign prostatic hyperplasia (an enlarged prostate gland that causes urinary difficulty), and retention of urine. R54's quarterly Minimum Data Set (MDS) assessment dated 8/15/24, indicated R54's BIMS (brief interview for mental status) score was 99 indicating R54 could not complete the interview. R54 had clear speech, could usually understand, and be understood. R54 had an indwelling urinary catheter. R54 was dependent on staff for activities of daily living. R54's physician orders dated 8/22/24, included urinary catheter: 16F (French) 10 cc (cubic centimeter) balloon for BPH (benign prostatic hyperplasia) with obstruction and urinary retention. R54's care plan dated 8/22/24, indicated R54 had a foley (a type of urinary catheter) indwelling catheter related to BPH with obstruction, and to connect to leg bag during the day and gravity drainage bag at night. Position catheter bag and tubing below the level of the bladder and away from entrance room door. During an observation on 11/6/24 at 8:58 a.m., R54 was in bed with his eyes closed. His entire urinary catheter bag was laying on the carpeted floor next to his bed. During an observation and interview on 11/6/24 at	21375			

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21375	Continued From page 19 9:19 a.m., the catheter bag was still on floor after licensed practical nurse (LPN)-G exited room after giving R54 medications. Together with LPN-G, returned to R54's room. When asked if it was acceptable to have the catheter bag laying on the floor, LPN-G replied, "I wondered that too" and "I don't think so." LPN-G donned gloves and hooked the catheter bag to the bed frame. LPN-G did not know who placed the bag on the floor and stated she found it in that location when she went into the room to give R54 his medications. LPN-G stated leaving the catheter bag on the floor could cause bacteria to get in the system and cause a UTI (urinary tract infection). During an interview on 11/6/24 at 10:03 a.m., registered nurse (RN)-F who was also the infection preventionist and staff development nurse, stated nursing staff were trained on orientation to make sure urinary catheter bags were not placed on the floor. RN-F stated the catheter bag could not rest on the floor or lay on the floor as bacteria could enter the port and migrate to the resident causing a UTI. During an interview on 11/6/24 at 11:14 a.m., RN-C who was also a nurse manager, stated staff were expected to hang the catheter bag on the bed frame and not allow it to rest on or lay on the floor; doing so could result in an infection. During an interview on 11/6/24, at 12:42 p.m., the director of nursing (DON) and the administrator were informed of findings. The DON stated catheter bags were never to be placed on the floor and staff had been trained to hang the bag on the bed frame or other surface to prevent that from occurring. The DON acknowledged a catheter bag laying on the floor could result in a UTI to the resident.	21375			

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21375	Continued From page 20 Facility Catheter Care (Indwelling) policy with revised date of 3/22, indicated the purpose of the policy was to prevent infection. The policy did not include proper positioning of a urinary drainage bag and/or to keep the bag off the floor. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise facility policies to ensure they contain all components of an infection control program, including appropriate care of urinary drainage bags. The DON or designee could educate appropriate staff and perform audits to ensure policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services	21530			12/12/24

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21530	Continued From page 21 and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to act upon the consultant pharmacist's recommendation for 2 of 5 residents (R55, R59) reviewed for unnecessary medications. Findings include: R59's significant change in status Minimum Data Set (MDS) assessment dated 10/19/24, indicated cognitively intact, required substantial/maximal assistance with toileting, transfers, shower/bathe,	21530	Corrected.		

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21530	Continued From page 22 dressing, personal hygiene, utilized a wheelchair, frequently incontinent of urine and bowel, diagnoses included: type one diabetes cancer, hypertension (high blood pressure), renal insufficiency (poor function of the kidneys), and chronic kidney disease. R59's document title Medication Regimen Review Report dated 9/21/24, consulting pharmacist (CP)-A indicated potential medication need: R59 with diabetes mellitus type one and CKD3 (chronic kidney disease stage 3) does not receive ACEI/ARB (angiotensin converting enzyme inhibitor and angiotensin receptor blocker therapy is a combination of two types of prescription medications that are commonly used to treat a variety of conditions therapy including chronic kidney disease), presence of albuminuria (sign of kidney disease and means that you have too much albumin in your urine) is unknown from records, no allergy/intolerance to ACEI/ARB noted in records. Recommendation: please follow-up on whether ACEI/ARB therapy is indicated for this individual. Order clarification: order for ASA (aspirin) 81 upon admission of 8/12/24, no indication for use nor stop date if applicable. On 11/6/24 at 11:30 a.m. R59's paper chart was located in the nursing station and included the CP-A's recommendation dated 9/21/24. R59's provider and nursing orders were reviewed and lacked documentation the facility had addressed CP-A recommendations. On 11/6/24 at 11:48 a.m., registered nurse (RN)-C, known as the nurse manager stated CP-A emailed the director of nursing (DON) with resident pharmacy recommendations. RN-C	21530			

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21530	Continued From page 23 stated she was not part of the pharmacy recommendations process, and confirmed R59's recommendation dated 9/21/24, was not addressed as expected. On 11/6/24 at 12:02 p.m., the director of nursing (DON) stated she received a monthly email from CP-A with resident's pharmacy and medication recommendations. The DON stated the email was forwarded to the health unit coordinator (HUC)-D who printed the recommendations and placed a hard copy of the pharmacy recommendation for the provider to address when next at the facility. The DON stated the provider was expected to address the pharmacy recommendations, and further stated she was responsible to ensure pharmacy recommendations were addressed. The DON confirmed R59's pharmacy recommendations dated 9/21/24, were not addressed as expected by the provider. R55's quarterly MDS assessment dated 10/18/24, indicated moderately impaired cognition, required maximal to moderate assistance with toileting, transfers and walking. Medications included anticoagulant, antidepressant, diuretic, anticonvulsant, and hypoglycemic. Active diagnoses included fractures, atrial fibrillation, heart failure, anemia, hypertension, renal insufficiency, diabetes, and chronic obstructive pulmonary disease. No psychiatric/mood disorder was indicated including anxiety or depression. R55's Medication Regimen Review Report dated 6/24/24, CP-A indicated potential medication need: R55 is taking duloxetine (antianxiety, antidepressant medication) with indication of cognitive impairment as diagnosis, is	21530			

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21530	Continued From page 24 inappropriate. Please link to an appropriate indication, or clarify with a provider if no indication for use has been issued. A progress note from pharmacy consultant dated 7/30/24, indicated medical record reviewed (MRR) with no concerns reported. A progress note from 9/10/24, included indication for duloxetine requested previously and this is second notice due to non-response. Inappropriate indication of cognitive impairment is currently linked to this agent. A progress note dated 10/20/24, included duloxetine inappropriate indication for use. This is 3rd notice issued. Administrative nursing staff emailed to ensure this is resolved. R55's provider orders last signed 10/23/24, by medical doctor (MD)-F, included duloxetine delayed release particles 30 mg one capsule one time a day for cognitive impairment. Initial order date of 6/5/24. On interview 11/6/24 at 12:47 p.m., RN-C, known as the nurse manager stated she is not involved in pharmacy reviews and added the director of nursing and the health unit coordinator (HUC) is responsible for those. On interview 11/6/24 at 12:56 p.m., the DON indicated it is the responsibility of both nurse managers to get the pharmacy recommendations completed. The DON then clarified stating RN-C started her employment in August 2024 and hasn't been trained on pharmacy reviews yet. The DON stated the pharmacy recommendations are electronically mailed (email) to her. The DON stated she does remember getting an email about	21530			

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21530	Continued From page 25 R55's duloxetine recommendations but had not acted on the recommendation at this time. On 11/6/24 at 12:05 p.m., a phone call was placed to CP-A and a voicemail was left and return phone call was not received from CP-A. Facility Medication Regimen Reviews policy dated 5/19, indicated: The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities, for example: medications ordered in excessive doses or without clinical indication; medication regimens that appear inconsistent with the resident's stated preferences; duplicative therapies or omissions of ordered medications; inadequate monitoring for adverse consequences; potentially significant drug-drug or drug-food interactions; potentially significant medication-related adverse consequences or actual signs and symptoms that could represent adverse consequences; incorrect medications, administration times or dosage forms; or other medication errors, including those related to documentation. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life threatening medication irregularity. The report contains: the resident's name;	21530			

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21530	Continued From page 26 the name of the medication; the identified irregularity; and the pharmacist's recommendation. An "irregularity" refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are being acted upon. TheQuality Assurance Performance Improvement (QAPI) committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530			
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final	21675			12/12/24

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21675	Continued From page 27 pH. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper infection control practices were followed when loose, and contaminated laundry was observed having been sent down the laundry chute without being secured in a laundry/plastic bag. This had the potential to affect all 68 residents who resided in the facility. Findings include: During an interview on 11/5/24 at 8:51 a.m., laundry aide (LA)-B stated resident linens were sent to the basement via a laundry chute located on each floor. Resident's personal clothing were done in unit laundry rooms. During an observation on 11/6/24 at 7:38 a.m., in the basement, the small room where laundry was deposited via laundry chutes from three floors was observed. The room had two yellow carts on wheels, positioned side by side. The carts were full of plastic bags of linen. In addition to the plastic bags, were loose towels and cloth gowns. On the floor were small pieces of maroon colored fabric resembling napkins. During a telephone interview on 11/6/24 at 8:06 a.m., facilitated by environmental services director (EVS)-H, laundry coordinator (LC)-H stated linens placed down the chute should be bagged. During an observation on 11/6/24 at 8:09 a.m., with EVS-H, together observed the laundry chute room. The cloth napkins had been picked up off	21675	Corrected.		

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21675	Continued From page 28 the floor and were in one of the carts. EVS-H acknowledged the loose towels and gowns in the carts, along with the plastic bagged linens. During an interview on 11/6/24 at 8:21 a.m., LA-B admitted staff did not always bag the linen - they were supposed to but were probably in a hurry and just tossed them down the chute. LA-B stated she usually saw loose towels, gowns, and washcloths; blankets and sheets were usually bagged. During an observation on 11/6/24 at 8:26 a.m., observed linen and garbage chutes on third floor across from the service elevator. There was no signage to inform staff not to place loose laundry down the chute. During an interview on 11/6/24 at 8:30 a.m., community assistant (CA)-C stated she threw loose linen, like towels down the laundry chute, adding that linen only needed to be bagged if there was biohazard or fecal material on them. During an interview on 11/6/24 at 9:14 a.m., CA-D stated linen should be placed in a plastic bag first before putting it down the chute, adding she was aware that sometimes staff threw laundry down the chute that wasn't bagged. During an interview 11/6/24 at 10:02 a.m., RN-F, who was also the infection preventionist, was informed of findings and stated staff were not supposed to throw loose linen down the laundry chute in order to prevent the potential spread of infection. During an interview on 11/6/24 at 12:42 p.m., the director of nursing (DON) and administrator were informed of findings. The DON stated staff were	21675			

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21675	Continued From page 29 aware to put linen in a plastic bag first before putting it down the chute; that it was an infection control concern if staff were carrying contaminated linen against their uniform. The DON stated laundry staff usually informed her when loose linens were being sent down the chute. Facility Soiled Linen Handling and Transportation policy dated 1/2020, indicated the purpose was to prevent contamination of laundry personnel, surfaces, and residents while handling soiled linens. Soiled linens were to be collected and transported in a sealed plastic bag to prevent spread of contaminants. The policy did not include procedure for placing soiled linen down the chute. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures for proper infection control measures when handling contaminated laundry, including placing contaminated laundry down the clothes chute, and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675			